VIRGINIA'S HEALTHCARE ACCESS, CAPACITY, AND PRIMARY CARE ISSUES. NATIONAL REPORTS AND SCOPE OF PRACTICE IMPLICATIONS.

Capacity Taskforce

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To Address Virginia's Capacity Issues, It is Important to Review National Reports Addressing Capacity Issues

Some of those who have "weighed in" in the past two years include:

- Council On Graduate Medical Education
- MedPac
- Health and Human Resources Service Administration
- Institute Of Medicine
- Health Care Associations:
  - American Medical Association and American Osteopathic Association
  - American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine
  - American Association of Nurse Practitioners
  - Primary Care Organizations: AAFP, ACOFP, AAP, ACOP,

COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

Authorized by Congress since 1986 to provide an ongoing assessment of:

- physician workforce trends,
- training issues,
- financing policies

And to advise the policymakers including the

- the Secretary of Dept. of Health and Human Services,
- the Senate Committee on Health Education, Labor and Pensions and
- the House of Representatives Committee on Commerce

on the supply and distribution of physicians, projected shortages, international medical graduate issues, graduate medical education financing, and the need to improve the database on supply and distribution of post-graduate training programs for physicians in the US

There are several reports of significance over the past few years

COGME's 16th Report: *Physician Workforce Policy Guidelines for the United States, 2000-2020.*

- This report outlined a significant gap between the expected physician supply, demand, and need.

  3 strategies were recommended:

  1. increase medical education & physician training capacity by 15% over the next decade;
  2. improve physician productivity; and
  3. establish a more rigorous & continuous assessment of the supply and demand for physicians in the U.S.

  As a result, the AAMC called for a 30% increase in enrollment in medical schools over the next ten years and a greater than 21% increase has occurred and the osteopathic schools have increase around 58% since 2002. Medical School enrollment increases (DO and MD) have met the COGME recommendations.

COGME Has Also Recognized 3 Imperatives to Establish an Adequate &Well Trained Future Physician Workforce

1) The number of Graduate Medical Education (GME) positions must be increased
2) Resident physicians must be trained in environments reflective of evolving healthcare delivery systems;
3) (outpatient vs. inpatient, medical homes, FQHCs)
4) The financing of GME must be realigned to achieve the above goals.

The Need to Increase Residency Positions to Increase Physician Supply

The medical schools have responded to increase physician supply, especially in Virginia where the number of medical school graduates have increased from 3 medical schools with approx. 400 in 2002 to an estimated 600 graduates in 2011, and 680 (or greater) in 2015 and beyond.

- The limitation nationwide and in Virginia is not having an adequate number of GME training positions.
- Current ACGME first year residency positions nationwide is 23,844
  - 71% filled allopathic or MD
  - 6.3% filled by osteopathic physicians
  - IMGs fill the remainder.
  - Currently just over 3300 AOA positions available with 54% fill rate
- By 2019,
  - 21,500 allopathic medical school graduates
  - Plus 5,500 osteopathic graduates
  - Need = 27,000 first-year positions just to place all US graduating physicians.
  - Estimated total positions ACGME and AOA available In 2019 = 27,200.

If international medical school graduates remains stable the gap in today's production there will be a shortage and there is a possibility that IMG applicants will essentially be eliminated causing the growth in physician supply to remain neutral. (By this date IMG applicants will also have to be from LCME accredited schools to take the ECFMG exam)

Much of GME funding comes from Medicare. University based GME receives 40% of GME costs from funding from Medicare while community based hospitals receive 90% of GME costs from Medicare funding.

What is COGME Recommending?
2010 COGME Meeting Recommendations:

Recommendation 1: Align GME with future healthcare needs

Increase funded GME positions by at least 15%

- to accommodate medical school expansion
- directed support towards
  - innovative training models which address community needs and which reflect emerging, evolving, and contemporary models of healthcare delivery.

Recommendation 2: Broaden the definition of "training venue" beyond traditional training sites.

- Decentralize training sites
- Create flexibility within the system which allows for exploration of new training venues while enhancing the quality of training for residents

Both recommendations make way for medical home and FQHC residency training sites

5 Core Areas Were Described to Determine New Programs and Position Funding

These five core areas describe the "Team Model"

1. Delivering patient-centered care
2. Working as part of interdisciplinary teams
3. Practicing evidence-based medicine
4. Focusing on quality improvement
5. Using information technology

COGME Recommendation 3

3. Remove regulatory barriers to executing flexible GME training programs and expanding training venues

- Address current CMS rules that limit expanding application of Medicare GME funds to nonhospital sites of care.
- Invite CMS to use its demonstration authority to fund innovative GME demonstration projects goal of preparing the next generation of physicians to achieve identified quality and patient safety outcomes.
- Assess and rewrite statutes and regulations that constrain flexible GME policies to respond to emergency situations and situations involving institutional and program closure.

COGME Recommendation 4

Make accountability for the public's health - the driving force for physician graduate medical education (GME)

- Develop mechanisms by which local, regional or national groups can determine workforce needs, assign accountability, assign funding, and develop innovative models of training which meet the needs of the community and of trainees
- Link continued funding to meeting pre-determined performance goals

2010 COGME Meeting Additional Considerations

Increasing The Number of Primary Care Physicians

- Recommendation: Policies supporting physicians providing primary care should be implemented that raise the percentage of primary care physicians (general internists, general pediatricians, and family physicians) among all physicians to at least 40% from the current level of 32%, a percentage that is actively declining at the present time.

2010 COGME Meeting

Mechanisms of Physician Payment and Practice:
Transformation for Primary Care

- Recommendation: To achieve the desired ratio of practicing primary care physicians, the average incomes of these physicians must achieve at least 70% of median incomes of all other physicians, as discussed in Section 2 of this report.
- Investment in primary care office practice infrastructure will also be needed to cope with the increasing burdens of chronic care and to provide comprehensive, coordinated care.
- Payment policies should be modified to support both of these goals including serving medically vulnerable populations in all areas of the country

2010 COGME Meeting

The Premedical and Medical School Environment

- Recommendation: Medical schools and academic health centers should develop an accountable mission statement and measures of social responsibility to improve the health of all Americans.
- Recommendation: Graduate Medical Education (GME) payment and accreditation policies and a significantly expanded Title VII program should support the goal of producing a physician workforce that is at least 40% primary care.
  - This goal should be measured by assessing physician specialty in practice rather than at the start of postgraduate medical training.
  - Achieving this goal will require a significant increase in current primary care production from residency training and major changes in resident physician training for the practice environment of the future.

Do COGME recommendations matter?
CMS Final Rule Changes In Residency Redistribution November 2010: A summary

- **Reductions to Hospitals' FTE Resident Caps for GME Payment with the purpose of redistribute residency positions.**
  Section 5503 CMS will take 65 percent of the DGME and IME funding for residency slots that have been unused by a hospital for 3 years and redistribute them according to certain criteria. Begins July 2011 (does not include new programs, or rural hospitals with less than 250 beds, or those currently in a voluntary resident reduction plan.)
  - **To determine the number of resident positions for redistribution, Medicare contractors will estimate the reduction to hospital's FTE caps and redistribute those positions.**
- **Reduction estimates must be completed by Medicare by May 16, 2011, to meet the July 1, 2011 deadline for implementation of the redistribution pool.**

Redistribution is to Rural and Primary Care

Criteria for Identifying Hospitals That Receive Increases or New FTE Resident Caps

- No new money: The number of positions received by qualifying hospitals will not exceed the total pool eligible for redistribution.
- If a hospital is awarded new positions, it must maintain its total FTE primary care residents averaged over its 3 most recent cost reporting periods ending prior to March 23, 2010.
- The hospital must use 75% of the redistributed positions for primary care (defined as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic rotating int.) or general surgery programs.
- Compliance must be documented every 5 years beginning July 1, 2011.
- Qualified applicants will not receive more than 75 FTEs total.
- Exceptions:
  - Rural hospitals are not required to use redistributed positions for new programs since they may start new specialty programs at any time.
  - Rural and urban teaching hospitals may apply for positions in the redistribution pool for new specialties or to expand existing programs.
  - Teaching hospitals without primary care programs may apply for additional positions to start primary care programs.

What is MedPac

An independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. Advises Congress on:

- payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program,
- analyzes access to care, quality of care, and other issues affecting Medicare.

The Commission's 17 members appointed to 3 year terms bring diverse expertise in the financing and delivery of health care services.

The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, public health, or medicine.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress.

MedPac Recommendations For GME

On GME on financing to focus on educational priorities included:

1. Congress should authorize the Secretary to change Medicare's funding of GME to support the workforce skills needed in a delivery system that reduce cost growth while maintaining or improving quality.
2. The Secretary should establish standards for distributing funds after consultation with representatives that include accrediting organizations, training programs, health care organizations, health care purchasers, patients, and consumers.
3. The standards established by the Secretary should, in particular, specify ambitious goals for practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, including integration of community-based care with hospital care.

MedPac Recommendations Include:

4. Improve Transparency of GME Funding: The Secretary should annually publish a report that shows Medicare medical education payments received by each hospital and each hospital's associated costs. This report should be publicly accessible and clearly identify each hospital, the direct and indirect medical education payments received, the number of residents and other health professionals that Medicare supports, and Medicare's share of teaching costs incurred.
5. The Secretary should conduct workforce analysis to determine the number of residency positions needed in the U.S. in total and by specialty. In addition, analysis should examine and consider the optimal level and mix of other health professionals. This work should be based on the workforce requirements of health care delivery systems that provide high-quality, high-value, and affordable care.
6. The Secretary should report to the Congress on how residency programs affect the financial performance of sponsoring institutions and whether residency programs in all specialties should be supported equally.
7. The Secretary should study strategies for increasing the diversity of our health professional workforce (e.g. increasing the shares from underrepresented rural, lower income, and minority communities) and report on what strategies are most effective to achieve this pipeline goal.

- Comment: Focusing on future distribution & primary care, (current maldistribution)

Health and Human Resources HRSA on the Future of Primary Care

- HRSA serves as the government's home on primary care services in the United States.
- The agency, a $7.5 billion concern, administers such programs as Community Health Centers and the National Health Service Corps. In its current capacity, HRSA provides care to 24 million medically underserved and uninsured people.
- In February 2009, President Obama named Mary Wakefield, R.N., Ph.D., as HRSA administrator. Mary Wakefield is considered an expert in rural health care, patient safety, Medicare payment policies and workforce issues.

October 2010, Mary Wakefield Weighed in on Primary Care (after IOM Report)

1. Cited family physicians as critically important to primary care as their focus is on prevention, health promotion, and management of chronic conditions.
2. Stated the Patient Protection and Affordable Care Act will provide a very clear role and need for the expertise that family medicine brings to the table.
3. Promoted the team approach through the patient-centered medical home as the focus for the work of HRSA. Cited this as the model for delivery of care to a variety of populations -- from mothers to infants to patients seen at community health centers to those served by Ryan White Clinics to patients seen in rural community health settings.
4. Stated HRSA will give attention to patient-centered medical homes through the advisory committee and the work of the Bureau of Health Professions.

How does this Affect the Capacity Task Force's Work?

- To Align with National Policy we should:
  - Increase Virginia's GME positions
  - Hold our Medical Schools, Academic Health Centers, and Community based hospitals accountable for missions that support improving the health of the entire community
  - Assure the appropriate funding and incentives exist to protect the primary care training programs and primary care practices, especially family medicine
  - Promote Team-Based Models of patient care that support quality healthcare and focus on patient outcomes.

How does the Affect the Work of the Capacity Task Force

- The Remainder of Today's presentations will focus on:
  - Team Based Models of Care
  - Primary Care
  - Are Changes of Scope Needed in the Team Based Approach

Considerations for Scope of Practice Changes Summary from National APN Website

Issues for legislators & regulatory bodies to consider when modifying a profession's scope of practice with the goal of public protection in mind.

- Historical basis for the profession, evolution of the profession, and the relationship of education and training to scope of practice requested
- Evidence related to how the revised scope of practice will benefit the public
- Capacity of the regulatory agency to manage scope of practice changes.
- Recognition of the reality of Overlapping scopes of practice and
- Criteria related to the qualifications to perform functions safely without risk of public harm are the justifiable conditions for defining scopes of practice.

(Liability and risk management issues must also be determined)

American College of Physicians (Internal Medicine) on Scope of Practice.

ACP released an 18-page policy paper on Feb. 17 that emphasized the importance of nurse practitioners and physicians cooperating to provide better access to primary care. Summary:

- The training of physicians and NPs is not the same but complementary.
  - Both share a commitment to providing high-quality care and
  - Recognizes there are many times when physicians are the best practitioner for patients.
- Collaboration is needed between physicians & NPs to improve quality of care.
- If considering Nurse led clinics, they recommended Dual demonstration projects for patient-centered medical homes, one physician-led and one NP led, both held to the same standards, and patients informed publicly whether a physician or NP is leading the model home.
- Greater research should be done about the best models of collaboration, referral and co-management of patients between NPs and physicians.
- Training for all health care professionals should be reformed, specifically in teaching teamwork and collaboration among multiple medical disciplines.
- Access to quality primary care through physicians and NPs must be ensured, with the understanding that training more NPs doesn't substitute for increasing the number of primary care physicians.

American Academy of Family Physicians set Standards on Supervision of APN, CNM, and Physician Assistants.

Summary The Guidelines were set because:

- The increasing variety of situations in which NPPs practice, the emphasis on practice teams, and the growing tendency of health policy makers to identify NPPs as a means of improving the availability of health care services
- The Academy policy on NPPs stipulates that these providers should always function under the "direction and responsible supervision" of a practicing, licensed physician.
- Academy policy on "Integrated Practice Arrangements" supports practice teams that including ANPs and believing that practicing physicians, ANPs and health policy makers benefit from a more detailed set of supervision guidelines.
- The guidelines are intended to serve as a set of general principles with which physicians, ANPs and policy makers can assess the roles of each in providing patient care in a team-based or medical home model and in improving access.

AAFP Guidelines for Physician Supervision of APNs, CNM, and PAs in a Team Model

Physician Responsibility Summary

- Central principle= physician retains ultimate responsibility of the patient care rendered when so required by state law. (compatible with current VA. Regulations)
- ANP supervision laws authorize the physician to be able to delegate the performance of certain medical acts to ANPs and others who meet specified criteria.
- The tasks delegated to the ANP must be within the scope of practice of the supervising physician, and he/she must assure all delegated activities are within the scope of the ANP's training and experience.
- The physician supervision must be adequate to ensure that the ANP provides care in accordance with accepted medical standards.

American Academy of Family Physicians on Supervision in Team Model

Supervision Summary

- It is the responsibility of the supervising physician to direct and review the work, records, and practice on a continuous basis to ensure that appropriate directions are given and understood and appropriate treatment rendered.
- Supervision includes, but is not limited to:
  - (1) the continuous availability of direct communication either in person or by electronic communications between the ANP and supervising physician;
  - (2) the personal review of the NPP's practice at regular intervals including an assessment of referrals made or consultations requested by the ANP;
  - (3) regular chart review;
  - (4) the delineation of a plan for emergencies;
  - (5) the designation of an alternate physician in the absence of the supervisor; and
  - (6) review plan for narcotic/controlled substance prescribing and formulary compliance. The circumstance of each practice determines the exact means by which responsible supervision is accomplished.

AAFP on Off-site Supervision

Off-site Supervision Summary

- In principle, supervision should recognize the diversity of practice settings, the efficient utilization of the ANP, and involve a physician-NPP team relationship.
- The supervising physician or a designated alternate physician of the same specialty must be available in person or by electronic communication at all times.
- There should be established clear transportation and backup procedures for the immediate care of patients needing emergency care and care beyond ANP's scope.
- As with on-site supervision, the appropriate degree of off-site supervision

  includes an overview of NPP's activities including a regular review of patient records; and periodic discussion of conditions, protocols, procedures, and patients.

(Current VA. Law may not allow for this type of off-site supervision and should be studied)

Additional Issues on Scope of Practice

Issues of concern by AMA, AAFP, and others focus on differences in training

- Difference in Primary Care Training
  - FP 11 years vs. APN 5.5 to 7 yrs (doctorate)
  - FP hrs of clinical training 20,000 to 21,000 while DPN is 2800 to 5500
- Physicians are not allowed to diagnose, treat, or prescribe independently until they have logged15,000 to 16,000 clinical hours (medical school plus 3 to 5 yrs of residency).
- APNs are required by Nurse Practitioner organizations to have between 500 and 1500 clinical hours to be prepared to diagnose and prescribe independently.

Issues to Consider to Build Primary Care Team Models

- What scope of practice changes would be needed if considering the Team Model approach that COGME, MedPac, and HRSA promote.
- How do you define in scope of practice regulations assuring patient care and safety without better defining the scope the differences in clinical training allow.

Proposed Policy Recommendations

- Virginia should provide initiatives to assure an adequate number of first year residency positions exist for the medical school graduates.
- Virginia should provide incentives to promote primary care residencies (current and new) and to promote re-distribution of residencies occur in rural and/or medically underserved areas.
- Virginia should support demonstration projects on physician-led and nurse-led primary care medical homes to include those in rural and medically underserved areas.
- To assure future capacity, safety in patient care, and a positive impact on or maintaining improving primary care physician supply, a study be performed on the scope of practice changes needed to effectively promote the Team Model of Care in Virginia.
  - The study should include representatives from all parties including: DNP, APN, CNM, and PA organizations in VA, and the MSV, VOMA, VAFP, VAOFP, and VA. Pediatric Association.